U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 June 2004

CASE NO. 2003-BLA-05886

In the Matter of

FRANK J. HARENZA,
Claimant

v.

NATIONAL MINES CORP.,
Employer

and

INTERNATIONAL BUSINES &
MERCANTILE REASSUREANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Anthony J. Kovach, Esq.
For the Claimant

George H. Thompson, Esq.
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed August 27, 2001. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed the instant claim, his third claim for benefits, on August 27, 2001. (Director's Exhibit "DX" 3). The record of the claimant's previous claims are contained in DX 1 and 2. The miner filed his first claim for federal black lung benefits on April 8, 1984 and that claim was denied by the Department of Labor on September 20, 1984, on the grounds that the evidence did not establish that claimant had pneumoconiosis which arose from coal mine employment, or total disability due to pneumoconiosis. (DX 1). Claimant did not appeal that decision nor request a formal hearing. Thus, the prior denial of September 20, 1984 is final. (DX 1).

Claimant filed a second claim for benefits on February 1, 1996. (DX 2). That claim was also denied by the District Director on April 12, 1996. The District Director found the evidence did not establish the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment, or total disability due to pneumoconiosis. Claimant did not appeal that decision nor request a formal hearing on the denial. Thus, the prior denial of April 12, 1996 is final. (DX 2).

On August 7, 2002, the Department of Labor issued a schedule for submission of additional evidence on this third claim for benefits and stated a preliminary conclusion had been made that the claimant would not be entitled to benefits. (DX 21). On January 31, 2003, the district director issued a proposed decision and order denying benefits finding the evidence does not show that the miner has pneumoconiosis which arose out of coal mine employment or that he is totally disabled by pneumoconiosis. (DX 36). The claimant, through counsel, requested a formal hearing on February 4, 2003. (DX 38).

The case was referred to the Office of Administrative Law Judges by the Director for a formal hearing on May 14, 2003. I was assigned the case on September 11, 2003. (DX 39). On January 14, 2004, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant and employer were represented by counsel. No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-11[1], Employer's exhibits ("EX") 1-7 and Director's exhibits ("DX") 1-57 were admitted into the record without objection. The

[1] Claimant's Exhibits as submitted were relabeled at the hearing after two x-ray reports were withdrawn prior to the hearing.

abbreviation "TR" denotes transcript of the hearing. Post-hearing, the employer submitted a closing brief.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether Claimant has demonstrated one of the applicable conditions of entitled has changed since the prior denials of April 12, 1996 and September 20, 1984?

FINDINGS OF FACT

I. Background

A. Coal Miner and Responsible Operator

Employer has stipulated that Claimant was employed as a miner after December 31, 1969 for 26 years in coal mine employment with the most recent coal mine employment being with the named responsible operator. Employer's stipulations are supported by the record. (DX 6). Accordingly, I find Claimant has established at least 26 years of coal mine employment. I further find the evidence supports Employer's stipulation that it is properly identified as the responsible operator.

B. Date of Filing

The claimant filed this third, or duplicate claim for benefits under the Act on August 27, 2001. (DX 3). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Dependents

The matter was not contested and I find the claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Sophia Cecelia Yanow Harenza whom he married on January 31, 1948. (DX 9; TR 9).

E. Personal, Employment and Smoking History

The claimant was born on February 12, 1922, and has a high school education. (DX 3). At the hearing, it was stipulated that he worked in the coal mines for at least 26 years. Claimant

testified he receives a miner's pension for 34 years of coal mine employment. (TR 10). Claimant testified he worked last in coal mine employment for National Mines Corp. as a roof bolter. (DX 10). Claimant left the mines in 1984 when he was 65 years old. (TR 10).

Mr. Harenza testified he is treated by Dr. Labuda. He takes two pills, but Claimant did not know what the medication was for. He has dizziness and shortness of breath on exertion. Claimant testified his breathing problems began in the 1970's or 1980's but they have gotten worse lately. He also coughs daily. (TR. 11-12). Claimant never smoked cigarettes.

II. *Medical Evidence*

The following is a summary of the evidence submitted. Because the miner did not have a formal hearing on either his first or second third claim, the medical evidence submitted with those claims is included below.

A. Chest X-rays[2]

There were fourteen readings of nine X-ray films, taken on March 10, 1994, June 7, 1984, January 19, 1995, February 20, 1996, April 3, 1996, September 17, 2001, October 11, 2001, August 29, 2002, and December 19, 2002. All of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b)[3].

Exh. #	**Dates 1. x-ray 2. read**	**Physician**	**Qualific-ations**[4]	**Quality**	**Classif-ication**	**Interpretation or Impression**
DX 1	06-07-84 07-11-84	McMahon	Not listed	1	0/0	
CX 7	03-10-94 09-08-94	Bassali	B, BCR	2	1/1 q, t	
CX 9	03-10-94 09-19-94	Mathur	B, BCR	1	1/2 p, q	
DX 2, EX 7	01-19-95 01-19-95	Scott	B, BCP	1	0/1 q, s	

[2] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[3] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[4] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations[4]	Quality	Classif-ication	Interpretation or Impression
DX 2	02-20-96 02-26-96	McMahon	Not listed	1	0/0	
DX 2	02-20-96 03-25-96	Gaziano	B, BCP	1	Not listed	Completely negative
DX 2	04-03-96 04-28-96	Fino	B, BCP	1	Not listed	Completely negative
DX 13	09-17-01 09-18-01	Cooperstein	Not listed		Not listed	Minimal scar or atelectasis, left base
DX 15	09-17-01 not listed	Pendergrass	B, BCR	1	Not listed	Completely negative
DX 13	09-17-01 12-26-01	Navani	B, BCR	2	Not listed	Completely negative
DX 14	10-11-01 11-01-01	Fino	B, BCP	1	Not listed	Completely negative
CX 1	08-29-02 09-04-02	Abrahams	Not listed	Not listed	1/0 t, s	
EX 2	08-29-02 11-22-02	Pendergrass	B, BCR	1	No pneumo-coniosis	1) Borderline lung parenchymal scarring at both lung bases, 2) evidence of healed granulomatous disease, punctale calcifications in both hilar regions, right greater than left, 3) no active disease seen
EX 1	12-19-02 01-28-03	Fino	B, BCP	1	Not listed	Completely negative

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; BCP-Board-Certified Pulmonologist; BCI= Board-Certified Internal Medicine. Readers who are board-certified radiologists and/ or B-readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983); *Billings v. Harlan #4 Coal Co.*, B.R.B. No. 94-3721 (June 19, 1997) (unpub). If no categories are chosen in box 2B of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[5]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). For a miner of the claimant's height of 68 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.87 for a male 68 years of age.[6] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.33; or an MVV equal to or less than 74; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. In addition, for a miner age 71, the regulations require an FEV-1 equal to or less than 1.73. Claimant's FEV-1 values on all tests taken after he reached age 72 exceed the regulatory value for a miner of 71 years. Extrapolation of the values required beyond age 71, therefore, is unnecessary since Claimant's values exceed even that regulatory requirement.

Physician Date Exh.#	**Age Height**[i]	**FEV_1**	**MVV**	**FVC**	**Tracings***	**Comprehension Cooperation**	**Qualify ** Conform*****	**Dr.'s Impression**
Garson 06/07/84 DX 1	62 68.5"	3.33	95.5	3.93	Yes	Good/good	No** Yes***	
Anderson 07/03/84 DX 1	62 69"	3.39	72	3.86	Yes	Good/good	No** Yes***	
Lebovitz 03/10/94 CX 4	72 68"	2.80	67.6	3.81	Yes	Good/good	No** Yes***	
Scott 01/19/95 EX 7	72 68"	3.17	---	3.99	yes		No** Yes***	Normal pulmonary function study, flow volume loop suggests inconsistent performance
Garson 02/20/96 DX 2	74 68"	3.16	64	4.32	Yes	Good/good	No** Yes***	
Fino 04/03/96 DX 2	74 68"	3.03	85	3.72	Yes	Good/good	No** Yes***	
Laute 09/17/01 DX 13	79 68"	1.98 2.58+	24.99 12.33+	3.18 3.16+	Yes Yes	Good/good	No** Yes***	

[5] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

[6] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 68" here, the most often reported height.

Physician Date Exh.#	Age Height[i]	FEV_1	MVV	FVC	Tracings*	Comprehension Cooperation	Qualify ** Conform***	Dr.'s Impression
Fino 10/11/01 DX 14	79 66.5"	2.72	78	3.47	Yes	Good/good	No** Yes***	
Gress 08/29/02 CX 1	79 68"	----	----	----	Yes		No***	Variability excessive, fails to meet quality standards
Fino 12/19/02 EX 1	80 68"	1.85 1.82+	45 --	2.59 2.90+	Yes Yes	Good/good	No** Yes***	

* A Judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-83 (1984).
** A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.
*** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103. (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).
+ Post-bronchodilator testing

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"
Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

C. Arterial Blood Gas Studies[7]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO_2	PO_2	Qualify	Physician Impression
06/07/84 DX 1	Garson	41.6 34.6 *	62.0 83.6 *	No No	
07/03/84 DX 1	Anderson	32.0 30.0 *	77.0 83.0 *	No No	
03/12/96 DX 2	Garson	32.0	86.0	No	
04/03/96 DX 2	Fino	33.0	82.0	No	

[7] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

Date Ex.#	Physician	pCO_2	PO_2	Qualify	Physician Impression
09/17/01 DX 13	Laute	37.0	64.0	No	
10/11/01 DX 14	Fino	35.0	66.0	No	
12/19/02 EX 1	Fino	36.0	75.0	No	

*Results after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. C. Anderson, whose credentials are not in the record, examined Claimant on behalf of the Department of Labor for his first claim on July 3, 1984. Dr. Anderson reported Claimant was a non-smoker who had worked in coal mine employment. Dr. Anderson reported a symmetrical chest on examination and lungs clear to auscultation and percussion. On laboratory studies, Dr. Anderson reported no evidence of pneumoconiosis on chest x-ray, good comprehension and cooperation on pulmonary function study which showed normal results and normal response at rest and after exercise on blood gas studies. Dr. Anderson stated Claimant may have a mild asthmatic bronchitis by history, but he stated there was no evidence of the asthmatic bronchitis on examination. Dr. Anderson also stated there is no evidence of any pneumoconiotic disease process and he concluded Claimant was capable of performing his usual coal mine employment. (DX 2).

On June 22, 1984, Dr. Y. Cho, whose qualifications are not in the record, examined Claimant and reported symptoms included cough, sputum production, wheezing and shortness of breath. Dr. Cho noted a slight increase on the AP diameter, but otherwise normal findings on examination of the miner's chest and lungs. Dr. Cho diagnosed mild hypoxia based on blood gas study results which he stated was due to coal mine employment. Dr. Cho did not, however, assess what limitations, if any, this mild hypoxia had caused. (DX 1).

Medical records from Dr. Labuda, Claimant's treating physician, whose credentials are not in the record, begin on January 20, 1992 when Claimant had an examination prior to cataract surgery. Dr. Labuda stated Claimant's lung were clear. Claimant was followed with various laboratory tests, for blood sugar and hyperlipidemia, until September, 1996. Claimant next visited Dr. Labuda in March, 2000 when a history of hyperlipidemia and BPH were noted. A

report dated June 7, 2000 noted Claimant was seen in the emergency room for cough and congestion. A chest x-ray showed an infiltrate consistent with pneumonia in the right lower lung. Claimant was seen again in August, 2000 for gout, and then for checkups in January, 2001, July, 2001 and January, 2002. Each of the check-up reports noted clear lungs and a diagnosis of hyperlipidemia and BPH. (EX 3). On January 7, 2004, Sandy in Dr. Labuda's office noted that there were no new records since Claimant had not been seen since January, 2002. (EX 6).

On March 26, 1994, Dr. J. Lebovitz examined Claimant. At a deposition taken on March 13, 1995, Dr. Lebovitz stated he was board eligible in internal medicine, but he failed the test for board certification in internal medicine six times. Dr. Lebovitz noted decreased breath sounds anteriorly and posterily, but no rales on physical examination. On chest x-ray, he reported coal worker's pneumoconiosis. Dr. Lebovitz also reported clubbing of the fingers and poor expansion of the chest. He concluded there was evidence of coal worker's pneumoconiosis. Dr. Lebovitz stated his diagnosis of coal worker's pneumoconiosis was based on the chest x-ray changes, clubbing of Claimant's fingers and poor expansion of his chest. In addition, he stated Claimant could not perform his usual coal mine employment based on the pulmonary function study abnormalities. At his deposition, however, Dr. Lebovitz reviewed the pulmonary function study results and agreed they did not show any restriction or obstruction. (CX 4, 6).

Dr. J. Scott, whose qualifications are not of record, examined Claimant on January 19, 1995 and reported on his examination on March 9, 1995. Dr. Scott reported Claimant had exertional dypsnea which had gradual gotten worse as well as a cough at night. Dr. Scott also reported Claimant was a non-smoker with thirty-seven years of coal mine employment. On physical examination, Dr. Scott reported normal chest with crackles at the base of the lungs which cleared with coughing and no wheezing. Dr. Scott stated there was no clubbing of the fingers. He noted normal results on pulmonary function study, chest x-ray findings of pneumoconiosis, 0/1 q and s, and normal sinus rhythm with non-specific t-wave changes on electrocardiogram. Dr. Scott also reviewed some medical records. He concluded there was no evidence of coal worker's pneumoconiosis or asbestosis or any other form of pneumoconiosis. In addition, Dr. Scott stated Claimant has a history of cough which is suggestive of chronic bronchitis, but there was no evidence of coughing during the examination. Dr. Scott stated the history suggests Claimant's cough is not industrial in original. Finally, he concluded that there was no evidence of any impairment of Claimant's respiratory system on the pulmonary test results. Thus, from a pulmonary standpoint, Claimant has the lung function to do his usual coal mine employment. (DX 2, EX 7).

On March 12, 1996, Dr. Gerson, whose credentials are not in the record, examined Claimant at the Centerville Clinic. He noted a history of sputum production with dypsnea and coughing. On inspection, palpation and percussion of Claimant's lungs, Dr. Gerson reported normal findings. He stated Claimant's lungs were clear to auscultation with no wheezes. Dr. Gerson reported no evidence of pneumoconiosis on chest x-ray and normal results on pulmonary function study and blood gas study. Dr. Gerson concluded Claimant has no significant lung disease. (DX 2).

On May 16, 2002, Dr. E. Rao, whose credentials are not in the record, noted Claimant's complaints of shortness of breath on exertion and occasional cough. He reported on examination, Claimant's AP diameter was increased with no masses or tenderness and normal excursion. Dr. Rao noted breath sounds were present bilaterally on auscultation with no rales, rhonchi or wheezing. On chest x-ray taken on December 26, there was no acute disease present. Dr. Rao also reported on results of blood gas study, spirometry and other pulmonary tests. He concluded Claimant has a combined mild to moderate airflow obstruction with mild restriction. He stated these change could be compatible with coal dust exposure. (EX 5). On July 27, 2002, Dr. Fiehler, whose credentials are not in the record, authored a report which he later stated was based on Dr. Rao's findings on physical examination since he did not personally examine Claimant. Dr. Fiehler reported chest x-ray on September 17, 2001 showed no evidence of pneumoconiosis and pulmonary function study taken on August 17, 2001 showed a mild obstructive and restrictive ventilatory defect. Dr. Fiehler diagnosed dypsnea on exertion secondary to obstructive/restrictive ventilatory defect. Dr. Fiehler stated the etiology of the diagnosed condition was coal dust exposure but he noted there is no evidence on chest x-ray to suggest pneumoconiosis. He stated, however, that symptomatatically Claimant has industrial bronchitis from coal dust which by definition is a form of pneumoconiosis. Dr. Fiehler concluded Claimant has a moderate impairment due to his occupational exposure. (DX 13, EX 5).

Dr. G. Gress, a board certified internist, examined Claimant on August 29, 2002 and reported on his findings on October 3, 2002. Dr. Gress noted Claimant's complaints of dypsnea on exertion and frequent daily cough. On physical examination, Dr. Gress reported Claimant's chest was symmetrical with no increase in the AP diameter and his lungs were clear to auscultation and percussion. Dr. Gress reported evidence of cyanosis of the lips and clubbing of the fingers. On chest x-ray he reported pneumoconiosis, 1/0 t and p and on pulmonary function study he stated the results were too variable to evaluate. On resting blood gas study, Claimant demonstrated borderline normal values, although at a deposition taken on January 30, 2003, he agreed the values were normal. Dr. Gress reviewed other medical evidence. He concluded Claimant has coal worker's pneumoconiosis based on his history, the chest x-ray results, the presence of dypsnea with cyanosis and clubbing, and the fact Claimant is a non-smoker. Dr. Gress stated the diagnosed condition is related to Claimant's history of coal mine employment and he concluded Claimant is totally disabled for employment due to the presence of coal worker's pneumoconiosis. (CX 1). At a deposition taken on January 30, 2003, Dr. Gress stated the finding of cyanosis is important since Claimant is a non-smoker with no heart disease. Therefore, he stated the cyanosis is a clear sign of lung disease. The fact that clubbing of the fingers is present is important since this is a change that occurs over many years. Dr. Gress stated the electrocardiogram results were generally normal, but a slight irregular heart rhythm was present. He also stated he did not review other chest x-ray films. Dr. Gress did agree on cross examination that there is no objective evidence of any pulmonary impairment since the pulmonary function study results were not useful due to variability and the blood gas study results were normal. (CX 3).

Dr. Fino, a board certified pulmonologist, examined Claimant several times. He initially examined Claimant on April 3, 1996 as part of Claimant's second claim for benefits. At that time, Dr. Fino concluded the findings on physical examination showed no evidence of

pneumoconiosis, the chest x-ray was negative and spirometry normal. In addition, Dr. Fino conducted other pulmonary tests and reviewed medical records. He concluded Claimant had no occupationally acquired pulmonary condition and from a respiratory functional standpoint, Claimant's pulmonary system was normal. (DX 2).

On October 11, 2001, Dr. Fino examined Claimant a second time. He noted a history of thirty-five years of coal mine employment and the fact Claimant was a non-smoker. Dr. Fino also noted Claimant left the mines in 1984 when he was 65 years old. Claimant worked as a roof bolter and rock duster and performed heavy manual labor. Dr. Fino reported Claimant's complaints of shortness of breath for twenty years, getting worse, and dypsnea on exertion, daily cough, mucous production and wheezes.

On physical examination, Dr. Fino reported Claimant's lungs were clear to auscultation and percussion on a tidal volume breath and forced expiration maneuver without wheezes, rales, rhonchi or rubs. On chest x-ray, Dr. Fino reported no evidence of coal worker's pneumoconiosis and spirometry was normal. In addition, Dr. Fino reported normal results on lung volume testing, diffusing capacity, oxygen saturation, carboxyhemoglobin, and electrocardiogram testing. He reported normal results on room air arterial blood gas studies taking Claimant's age into account. Dr. Fino also reviewed the medical evidence. He concluded Claimant had a normal pulmonary examination with no evidence of an occupationally acquired pulmonary condition. This finding was based on: 1) the negative chest x-ray reading by Dr. Fino; 2) the normal results on spriometric evaluation; 3) the normal results on diffusing capacity which rules out clinically significant pulmonary fibrosis; and, 4) the fact the TLC was not reduced which rules out a restrictive lung disease and significant pulmonary fibrosis. Dr. Fino stated, therefore, from a functional standpoint, Claimant's pulmonary system is normal with no ventilatory impairment on normal spirometry and the normal diffusing capacity and lack of impairment in oxygen transfer. Dr. Fino's final conclusions included: 1) insufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis; 2) there is no occupationally acquired pulmonary condition; 3) there is no respiratory impairment; 4) from a respiratory standpoint, Claimant is not partially nor totally disabled from coal mine employment or similar work; and 5) even if medical or legal pneumoconiosis were present, the findings on Claimant's respiratory capability would not change. (DX 14).

On December 19, 2002 and January 9, 2003, Dr. Fino examined Claimant for a third time. He noted in his report dated January 28, 2003, Claimant had performed many of the pulmonary tests on December 19, 2002 when Dr. Fino was called out for an emergency so the physical examination was conducted later, on January 9, 2003. Dr. Fino's findings on examination and testing were very similar to those set forth above from his October, 2001 report. Dr. Fino again concluded Claimant had a normal pulmonary examination. He stated there was no clinical or legal pneumoconiosis present based on: 1) the majority of chest x-ray readings were negative for pneumoconiosis; 2) his own readings of chest x-ray films was negative for pneumoconiosis; 3) the acceptable spriometric evaluations were normal with no evidence of obstruction, restriction or ventilatory impairment; 4) the diffusing capacity was normal which rules out significant pulmonary fibrosis; 5) there is no impairment in oxygen transfer; and 6) the total lung capacity was not reduced which rules out a restrictive lung disease and significant pulmonary fibrosis. From a functional standpoint, Dr. Fino again concluded Claimant's

pulmonary system was normal and he retains the physiologic capacity from a respiratory standpoint to do the requirements of his last job based on: 1) no ventilatory impairment based on normal spirometry; 2) normal diffusing capacity which rules out any impairment in transfer of oxygen; 3) blood gas at rest and exercise showed no significant hypoxemia with no evidence of significant impairment in oxygen transfer and 4) with good effort, his MVV values were normal. Dr. Fino again concluded there is insufficient objective evidence to justify a diagnosis of clinical or legal pneumoconiosis. In addition, he stated Claimant has no respiratory impairment and, for the reasons noted, from a respiratory standpoint, he is nether partially nor totally disabled. Finally, Dr. Fino stated even if pneumoconiosis were present, his findings on Claimant's pulmonary capacity would not change. (EX 1). At a deposition taken on July 2, 2003, Dr. Fino stated he saw no clubbing of Claimant's fingers on the three examinations he conducted. He also noted that Claimant's values on spirometry testing were normal, even when Claimant did not perform with maximal effort. Thus, Dr. Fino found no evidence of any change in Claimant's pulmonary status. (EX 4).

III. Conclusions of Law

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987).

Since this is the claimant's third claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[8] Claimant must initially

[8] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. 725.309(d). As a threshold matter, all factors essential to entitlement were previously adjudicated against the claimant in the 1984 and 1996 denials: that he suffers from pneumoconiosis caused by coal mine employment, or that he is totally disabled due to pneumoconiosis.

B. Existence of Pneumoconiosis and Cause of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[9] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[10]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." Thus, "pneumoconiosis",

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(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

[9] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*); *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-15 (3rd Cir. 1995).

[10] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

as defined by the Act, has a much broader legal meaning than does the medical definition. "…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[11] 20 C.F.R. § 718.202(a)(4).

The Third Circuit has held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams & Director, OWCP*, 114 F.3d 22 (3rd Cir. June 3, 1997) *Citing* 30 U.S.C. § 923(b) and *Kertesz v. Cresent Hills Coal Co.*, 788 F.2d 158 (3d Cir. 1986).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." Readers who are Board-certified radiologists and/or B-readers are classified as the most

[11] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

In the x-ray evidence submitted with the prior claim, all the x-ray readings were negative for pneumoconiosis, including readings by a board-certified radiologists and B-readers. Of the nine readings submitted with this most recent application, two readings by Drs. Bassali and Mathur of an x-ray film from March, 1994 are positive, one reading by Dr. Abrahams of an x-ray film from August, 2002 is positive while six readings of x-ray films from 2001, 2002 and 2003 are negative. These negative readings include readings by Drs. Pendergrass, Navani, and Fino who are highly qualified as board certified radiologists and/or B-readers. These are comparable to the positive readings by Drs. Bassali and Mathur, who are also highly qualified. Since the negative readings by highly qualified physicians include both the readings from the prior claims covering the years 1984 through 1996, as well as the x-ray readings from this claim from September 2001 through December, 2002, I find the extent of the negative readings over this eighteen year period outweighs the two readings of the March, 1994 x-ray film. Accordingly, I find the negative x-ray readings outweigh the positive readings of record.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[12] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of his Board-certification and B-reader status and expertise, as noted above, I rank Dr. Fino as most qualified to assess Claimant's pulmonary condition. Dr. Labuda was Mr. Harenza's treating physician. However, the treatment records do not discuss any findings of pneumoconiosis or other chronic pulmonary conditions. Therefore, the treatment records will not be accorded special weight as those from a treating physicians under the criteria of section 718.104(d).

[12] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.,* 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4).

On reviewing the medical opinion reports, the physicians disagree as to whether Claimant has any pulmonary changes present. I find Dr. Fino's three examination reports are better reasoned and better supported since they include extensive pulmonary testing in addition to the pulmonary function study and blood gas study conducted by other physicians. Dr. Fino's conclusion that pneumoconiosis is not present is based on the negative chest x-ray reports and on additional specific findings on extensive pulmonary testing including the results of spriometric evaluations, blood gas study, diffusion capacity testing and total lung capacity testing. As noted, Dr. Fino is highly qualified as a board certified pulmonologist. Under these circumstances, I find Dr. Fino's well reasoned and well supported report outweighs the contrary reports of record.

As noted above, however, the regulations also provide that pneumoconiosis may be established where any chronic lung disease or impairment and its sequelae arises out of coal mine employment. Based on Dr. Fino's well reasoned and well supported reports, however, I find the evidence does not establish any chronic lung condition arising out of coal mine employment or from any other cause is present, thus, there is no credible evidence of either medical or legal pneumoconiosis.

In summary, the well reasoned and well supported conclusions of Dr. Fino that neither medical nor legal pneumoconiosis is not present outweighs the contrary medical opinion reports of record. Thus, after considering all the medical opinion reports and other medical evidence, I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

Furthermore, when the evidence is weighed together, I find the persuasive negative chest x-ray readings and Dr. Fino's probative and persuasive medical opinion reports outweigh the contrary evidence of record. Therefore, the evidence is not sufficient to support a finding of the existence of coal workers' pneumoconiosis pursuant to § 718.202(a). As this element of entitlement was previously adjudicated against the Claimant, I find that he has not proven this element of entitlement previously denied has changed since the denial of his prior claims.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of coal worker's pneumoconiosis has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein. Therefore, claimant has not established this element of entitlement has changed since the prior denial of his claims.

D. Total Disability

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[13] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[14] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Since Claimant has not demonstrated qualifying values on any of the pulmonary function studies, I find Claimant has not established total disability under the provisions of Section 718.204(b)(2)(i) on the two most recent pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. Section 718.204(b)(2)(ii). Claimant's values on all the blood gas studies were non-qualifying. Therefore, I find Claimant has not established total disability under the provisions of Section 718.204(b)(2)(ii).

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Although some physicians concluded Claimant is totally disabled due to his pulmonary condition, I find Dr. Fino's evaluation of Claimant's

[13] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

[14] 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

pulmonary condition most persuasive. As noted above, Dr. Fino is highly qualified as a pulmonologist. In addition, he supports his conclusions with results of extensive pulmonary testing. Under these circumstances, I find Dr. Fino's opinion most persuasive and I find it outweighs the contrary medical opinion reports of record. Accordingly, I find Claimant has not established total disability under Section 718.204(b)(2)(iv).

On consideration of all of the medical evidence, I find the evidence does not establish Claimant is totally disabled by a respiratory or pulmonary condition under Section 718.204(b)(2).

E. Cause of total disability

The revised regulation at 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." Since I find Claimant has not established total disability due to his respiratory or pulmonary condition nor has he established the presence of pneumoconiosis, he has clearly failed to establish total disability due to pneumoconiosis.

Since Claimant has not established that he is totally disabled due to pneumoconiosis under Section 718.204, he has not established that applicable condition of entitlement has changed since it was previously adjudicated against him.

F. Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for representation services rendered to him in pursuit of his claim.

CONCLUSION

In conclusion, the claimant has not established that any of the applicable conditions of entitlement have changed since the prior denial. Thus, his claim must be denied on the basis of the prior denials pursuant to Section 725.309(d). He has also failed to establish the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment or that he is totally disabled due to pneumoconiosis. Thus, the claimant is not entitled to benefits.

ORDER[15]

It is ordered that the claim of Frank J. Harenza for benefits under the Black Lung Benefits Act is hereby DENIED.

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[16]

[15] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[16] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.